MARYLAND HEALTH CARE COMMISSION

_____
MATTER/DOCKET NO.

_____
DATE DOCKETED

OTHER THAN HOSPITAL AND COMPREHENSIVE/ EXTENDED CARE SERVICES APPLICATION FOR CERTIFICATE OF NEED

ALL PAGES THROUGHOUT THE APPLICATION SHOULD BE NUMBERED CONSECUTIVELY.

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1.a. _____
Legal Name of Project Applicant
(ie. Licensee or Proposed Licensee)

b. _____
Street

c. _____
City Zip County

d. _____
Telephone No.

e. _____
Name of Owner/Chief Executive

2.a. _____
Legal Name of Project Co-Applicant
(ie. if more than one applicant)

b. _____
Street

c. _____
City Zip County

d. _____
Telephone

e. _____
Name of Owner/Chief Executive

3.a. _____
Name of Facility

b. _____
Street (Project Site)

c. _____
City Zip County

4. _____
Name of Owner (if different than applicant)

5.a. _____
Representative of Co-Applicant

b. _____
Street

c. _____
City Zip County

d. _____
Telephone

6. Person(s) to whom questions regarding this application should be directed: (Attach sheets if additional persons are to be contacted)

a. _____ a._____
Name and Title Name and Title

b. _____ b._____
Street Street

c. _____ c._____
City Zip County City Zip County

d. _____ d._____
Telephone No. Telephone No.

e. _____ e._____
Fax No. Fax No.

7. Brief Project Description (for identification only; see also item #14):
_____
_____
_____
_____

8. Legal Structure of Licensee (check one from each column):

a. Governmental ___ b. Sole Proprietorship ___ c. To be Formed ___
Proprietary ___ Partnership ___ Existing ___
Nonprofit ___ Corporation ___
Subchapter "S" ___

9. Project Services (check below, if applicable):

Service	Included in Project
ICF-MR	
ICF-C/D	
Home Health Agency	
Residential Treatment Center	
Ambulatory Surgery	
Other (Specify)	

10. Current Capacity and Proposed Changes:

Service	Unit Description	Currently Licensed/ Certified	Units to be Added or Reduced	Total Units if Project is Approved
ICF-MR	Beds	____/____		
ICF-C/D	Beds	____/____		
Residential Treatment	Beds	____/____		
Ambulatory Surgery	Operating Rooms			
	Procedure Rooms			
Home Health Agency	Counties	____/____		
Hospice Program	Counties	____/____		
Other (Specify)				
TOTAL				

11. Project Location and Site Control:

A. Site Size _____ acres

B. Have all necessary State and Local land use approvals, including zoning, for the project as proposed been obtained? YES_____ NO _____ (If NO, describe below the current status and timetable for receiving necessary approvals.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

C. Site Control:

(1) Title held by: _____

(2) Options to purchase held by: _____
(i) Expiration Date of Option _____
(ii) Is Option Renewable? _____ If yes, Please explain
_____
_____
(iii) Cost of Option _____

(3) Land Lease held by: _____

(i) Expiration Date of Lease _____

(ii) Is Lease Renewable _____ If yes, please explain

_____

_____

(iii) Cost of Lease _____

(4) Option to lease held by: _____

(i) Expiration date of Option _____

(ii) Is Option Renewable?_____ If yes, please explain

_____

_____

(iii) Cost of Option _____

(5) If site is not controlled by ownership, lease, or option, please explain how site control will be obtained_____

_____

(INSTRUCTION: IN COMPLETING ITEMS 12, 13 & 14, PLEASE NOTE APPLICABLE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

12. Project Implementation Target Dates (for construction or renovation projects):

A. Obligation of Capital Expenditure _____ months from approval date.
B. Beginning Construction _____ months from capital obligation.
C. Pre-Licensure/First Use _____ months from capital obligation.
D. Full Utilization _____ months from first use.

13. Project Implementation Target Dates (for projects <u>not</u> involving construction or renovations):

A. Obligation of Capital Expenditure _____ months from approval date.
B. Pre-Licensure/First Use _____ months from capital obligation.
C. Full Utilization _____ months from first use.

14. Project Implementation Target Dates (for projects <u>not</u> involving capital expenditures):

A. Obligation of Capital Expenditure _____ months from approval date.
B. Pre-Licensure/First Use _____ months from capital obligation.
C. Full Utilization _____ months from first use.

15. Project Description:
Provide a summary description of the project's construction and renovation plan and all medical services to be establish, expanded, or otherwise affected if the project receives approval. Please attach this description as a separate sheet or section to your application.

16. Project Drawings:

Projects involving renovations or new construction should include architectural schematic drawings or plans outlining the current facility (if applicable), the new facility (if applicable) and the proposed new configuration for inpatient facilities. These drawings should include:

1) the number and location of nursing stations,
2) approximate room sizes,
3) number of beds to a room,
4) number and location of bath rooms,
5) any proposed space for future expansion, and
6) the "footprint" and location of the facility on the proposed or existing site.

For free-standing (including office-based) ambulatory surgical facilities, these drawings should include:

1) dimensions of major architectural features and equipment of all operating rooms and procedure rooms, existing and proposed,
2) clear demarcation of restricted sterile corridor,
3) any proposed space for future expansion, and
4) the "footprint" and location of the facility on the proposed or existing site.

17. Features of Project Construction:

A. Please Complete **"CHART 1. PROJECT CONSTRUCTION CHARACTERISTICS"** describing the applicable characteristics of the project, if the project involves new construction.

B. Explain any plans for bed expansion subsequent to approval which are incorporated in the project's construction plan.

_____

_____

C. Please discuss the availability of utilities (water, electricity, sewage, etc.) for the proposed project, and the steps that will be necessary to obtain utilities._____

_____

Chart 1. Project Construction Characteristics and Costs		
Base Building Characteristics	Complete if Applicable	
	New Construction	Renovation
Class of Construction		
Class A		
Class B		
Class C		
Class D		
Type of Construction/Renovation		
Low		
Average		
Good		
Excellent		
Number of Stories		
Total Square Footage		
Basement		
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Perimeter in Linear Feet		
Basement		
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Wall Height (floor to eaves)		
Basement		
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Elevators		
Type *Passenger* *Freight*		
Number		
Sprinklers (Wet or Dry System)		
Type of HVAC System		
Type of Exterior Walls		

Chart 1. Project Construction Characteristics and Costs (cont.)		
	Costs	Costs
Site Preparation Costs	$	$
Normal Site Preparation*		
Demolition		
Storm Drains		
Rough Grading		
Hillside Foundation		
Terracing		
Pilings		
Offsite Costs	$	$
Roads		
Utilities		
Jurisdictional Hook-up Fees		
Signs	$	$
Landscaping	$	$

*As defined by Marshall Valuation Service. Copies of the definitions may be obtained by contacting staff of the Commission.

PART II - PROJECT BUDGET

INSTRUCTION: All estimates for 1.a.-d., 2.a.-j., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. (DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. Use of Funds

1. Capital Costs:

a.	New Construction	$ _____
(1)	Building	_____
(2)	Fixed Equipment (not included in construction)	_____
(3)	Land Purchase	_____
(4)	Site Preparation	_____
(5)	Architect/Engineering Fees	_____
(6)	Permits, (Building, Utilities, Etc)	_____
SUBTOTAL		$ _____
b.	Renovations	
(1)	Building	$ _____
(2)	Fixed Equipment (not included in construction)	_____
(3)	Architect/Engineering Fees	_____
(4)	Permits, (Building, Utilities, Etc.)	_____
SUBTOTAL		$ _____
c.	Other Capital Costs	
(1)	Major Movable Equipment	_____
(2)	Minor Movable Equipment	_____
(3)	Contingencies	_____
(4)	Other (Specify)	_____
TOTAL CURRENT CAPITAL COSTS (a - c)		$ _____
d.	Non Current Capital Cost	
(1)	Interest (Gross)	$ _____
(2)	Inflation (state all assumptions, Including time period and rate)	$ _____
TOTAL PROPOSED CAPITAL COSTS (a - d)		$ _____

2. Financing Cost and Other Cash Requirements:

a.	Loan Placement Fees	$ _____
b.	Bond Discount	_____
c.	Legal Fees (CON Related)	_____
d.	Legal Fees (Other)	_____
e.	Printing	_____
f.	Consultant Fees	
	CON Application Assistance	_____
	Other (Specify)	_____
g.	Liquidation of Existing Debt	_____
h.	Debt Service Reserve Fund	_____
i.	Principal Amortization Reserve Fund	_____
j.	Other (Specify)	_____
	TOTAL (a - j)	$ _____

3. Working Capital Startup Costs $ _____

TOTAL USES OF FUNDS (1 - 3) $ _____

B. Sources of Funds for Project:

1.	Cash	_____
2.	Pledges: Gross _____, less allowance for uncollectables _____ = Net	_____
3.	Gifts, bequests	_____
4.	Interest income (gross)	_____
5.	Authorized Bonds	_____
6.	Mortgage	_____
7.	Working capital loans	_____
8.	Grants or Appropriation	
	(a) Federal	_____
	(b) State	_____
	(c) Local	_____
9.	Other (Specify)	_____

TOTAL SOURCES OF FUNDS (1-9) $ _____

Lease Costs:

a. Land	$_____	x _____	= $_____
b. Building	$_____	x _____	= $_____
c. Major Movable Equipment	$_____	x _____	= $_____
d. Minor Movable Equipment	$_____	x _____	= $_____
e. Other (Specify)	$_____	x _____	= $_____

PART III - CONSISTENCY WITH REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

(INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G. Each criterion is listed below.)

10.24.01.08G(3)(a). The State Health Plan.

List each standard from the applicable chapter of the State Health Plan and provide a direct, concise response explaining the project's consistency with that standard. In cases where standards require specific documentation, please include the documentation as a part of the application. **(Copies of the State Health Plan are available from the Commission. Contact the Staff of the Commission to determine which standards are applicable to the Project being proposed.)**

10.24.01.08G(3)(b). Need.

For purposes of evaluating an application under this subsection, the Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

Please discuss the need of the population served or to be served by the Project.

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. For applications proposing to address the need of special population groups identified in this criterion, please specifically identify those populations that are underserved and describe how this Project will address their needs.

[(INSTRUCTION: Complete Table 1 for the Entire Facility, including the proposed project, and Table 2 for the proposed project only using the space provided on the following pages. Only existing facility applicants should complete Table 1. All Applicants should complete Table 2. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)]

TABLE 1: <u>STATISTICAL PROJECTIONS - ENTIRE FACILITY</u>

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
1. Admissions							
a. ICF-MR							
b. RTC-Residents							
Day Students							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
2. Patient Days							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							

Table 1 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
3. Average Length of Stay							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
4. Occupancy Percentage*							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
5. Number of Licensed Beds*							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
6. Home Health Agencies							
a. SN Visits							
b. Home Health Aide							
c. Other Staff							
d.							
e. Total patients srvd.							

Table 1 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
7. Hospice Programs							
a. SN visits							
b. Social work visits							
c. Other staff visits							
d.							
e. Total patients srvd.							
8. Ambulatory Surgical Facilities							
a. Number of operating rooms (ORs)							
● Total Procedures in ORs							
● Total Cases in ORs							
● Total Surgical Minutes in ORs**							
b. Number of Procedure Rooms (PRs)							
● Total Procedures in PRs							
● Total Cases in PRs							
● Total Minutes in PRs**							

*Number of beds and occupancy percentage should be reported on the basis of licensed beds.
**Do not include turnover time.

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT
(INSTRUCTION: All applicants should complete this table.)

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___
1. Admissions				
a. ICF-MR				
b. RTC-Residents				
Day Students				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
2. Patient Days				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
3. Average Length of Stay				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
4. Occupancy Percentage*				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				

Table 2 Cont.	Projected Years

	(Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___
5. Number of Licensed Beds				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
6. Home Health Agencies				
a. SN Visits				
b. Home Health Aide				
c.				
d.				
e. Total patients served				
7. Hospice Programs				
a. SN Visits				
b. Social work visits				
c. Other staff visits				
d. Total patients served				
8. Ambulatory Surgical Facilities				
a. Number of operating rooms (ORs)				
● Total Procedures in ORs				
● Total Cases in ORs				
● Total Surgical Minutes in ORs**				
b. Number of Procedure Rooms (PRs)				
● Total Procedures in PRs				
● Total Cases in PRs				
● Total Minutes in PRs**				

*Do no include turnover time

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

For purposes of evaluating an application under this subsection, the Commission shall compare the cost-effectiveness of providing the proposed service through the proposed project with the cost-effectiveness of providing the service at alternative existing facilities, or alternative facilities which have submitted a competitive application as part of a comparative review.

Please explain the characteristics of the Project which demonstrate why it is a less costly or a more effective alternative for meeting the needs identified.

For applications proposing to demonstrate superior patient care effectiveness, please describe the characteristics of the Project that will assure the quality of care to be provided. These may include, but are not limited to: meeting accreditation standards, personnel qualifications of caregivers, special relationships with public agencies for patient care services affected by the Project, the development of community-based services or other characteristics the Commission should take into account.

10.24.01.08G(3)(d). Viability of the Proposal.

For purposes of evaluating an application under this subsection, the Commission shall consider the availability of financial and non-financial resources, including community support, necessary to implement the project within the time frame set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Please include in your response:

a. Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. The availability of each source of funds listed in Part II, B. Sources of Funds for Project, must be documented.

b. Existing facilities shall provide an analysis of the probable impact of the Project on the costs and charges for services at your facility.

c. A discussion of the probable impact of the Project on the cost and charges for similar services at other facilities in the area.

d. All applicants shall provide a detailed list of proposed patient charges for affected services.

(INSTRUCTIONS: Table 3, "Revenue and Expenses - Entire Facility **(including the proposed project)" is to be completed by existing facility applicants only. Applicants for new facilities should not complete Table 3. Table 4,** "Revenues and Expenses - Proposed Project," **is to be completed by each applicant for the proposed project only. Table 5**, "Revenues and Expenses (for the first full year of utilization", **is to be completed by each applicant for each proposed service in the space provided. Specify whether data are for calendar year or fiscal year. All projected revenue and expense figures should be presented in current dollars. Medicaid revenues for all years should be calculated on the basis of Medicaid rates and ceilings in effect at the time of submission of this application. Specify sources of non-operating income. State the assumptions used in projecting all revenues and expenses.)**

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)

(INSTRUCTION: ALL EXISTING FACILITY APPLICANTS MUST SUBMIT AUDITED FINANCIAL STATEMENTS)

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
1. Revenue							
a. Inpatient services							
b. Outpatient services							
c. Gross Patient Service Revenue							
d. Allowance for Bad Debt							
e. Contractual Allowance							
f. Charity Care							
g. Net Patient Services Revenue							
h. Other Operating Revenues (Specify)							
i. Net Operating Revenue							

Table 3 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle	20___	20___	20___	20___	20___	20___	20___
2. Expenses							
a. Salaries, Wages, and Professional Fees, (including fringe benefits)							
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies							
j. Other Expenses (Specify)							
k. Total Operating Expenses							
3. Income							
a. Income from Operation							
b. Non-Operating Income							
c. Subtotal							
d. Income Taxes							
e. Net Income (Loss)							

Table 3 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
4. Patient Mix: A. Percent of Total Revenue							
1. Medicare							
2. Medicaid							
3. Blue Cross							
4. Commercial Insurance							
5. Self-Pay							
6. Other (Specify)							
7. TOTAL	100%	100%	100%	100%	100%	100%	100%
B. Percent of Patient Days/Visits/Procedures (as applicable)							
1. Medicare							
2. Medicaid							
3. Blue Cross							
4. Commercial Insurance							
5. Self-Pay							
6. Other (Specify)							
7. TOTAL	100%	100%	100%	100%	100%	100%	100%

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

(INSTRUCTION: Each applicant should complete this table for the proposed project only)

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___
1. Revenues				
a. Inpatient Services				
b. Outpatient Services				
c. Gross Patient Services Revenue				
d. Allowance for Bad Debt				
e. Contractual Allowance				
f. Charity Care				
g. Net Patient Care Service Revenues				
h. Total Net Operating Revenue				
2. Expenses				
a. Salaries, Wages, and Professional Fees, (including fringe benefits)				
b. Contractual Services				
c. Interest on Current Debt				
d. Interest on Project Debt				
e. Current Depreciation				
f. Project Depreciation				
g. Current Amortization				
h. Project Amortization				
i. Supplies				
j. Other Expenses (Specify)				
k. Total Operating Expenses				

Table 4 Cont.	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___
3. Income				
a. Income from Operation				
b. Non-Operating Income				
c. Subtotal				
d. Income Taxes				
e. Net Income (Loss)				
4. Patient Mix: A. Percent of Total Revenue				
1. Medicare				
2. Medicaid				
3. Blue Cross				
4. Commercial Insurance				
5. Self-Pay				
6. Other (Specify)				
7. TOTAL	100%	100%	100%	100%
5. Ambulatory Surgical Facilities				
1. Medicare				
2. Medicaid				
3. Blue Cross				
4. Commercial Insurance				
5. Self-Pay				
6. Other (Specify)				
7. TOTAL	100%	100%	100%	100%

10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

To meet this subsection, an applicant shall demonstrate compliance with all conditions applied to previous Certificates of Need granted to the applicant.

List all prior Certificates of Need that have been issued to the project applicant by the Commission since 1995, and their status.

10.24.01.08G(3)(f). Impact on Existing Providers.

For evaluation under this subsection, an applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers.

Indicate the positive impact on the health care system of the Project, and why the Project does not duplicate existing health care resources. Describe any special attributes of the project that will demonstrate why the project will have a positive impact on the existing health care system.

Complete Table 5

1. an assessment of the sources available for recruiting additional personnel;

2. recruitment and retention plans for those personnel believed to be in short supply;

3. for existing facilities, a report on average vacancy rate and turnover rates for affected positions,

(INSTRUCTION: FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours.

TABLE 5. MANPOWER INFORMATION

(INSTRUCTION: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project.)

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration					
Direct Care					
Support					
				Benefits	_____
				TOTAL	_____

(INSTRUCTION: Indicate method of calculating benefits percentage):

_____

_____

_____

PART IV - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY,

AUTHORIZATION AND SIGNATURE

1. List the name and address of each owner or other person responsible for the proposed project and its implementation. If the applicant is not a natural person, provide the date the entity was formed, the business address of the entity, the identify and percentage of ownership of all persons having an ownership interest in the entity, and the identification of all entities owned or controlled by each such person.

_____
_____
_____
_____
_____

2. Is the applicant, or any person listed above now involved, or ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each facility, including facility name, address, and dates of involvement.

_____
_____
_____
_____

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Questions 1 and 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owner or other person responsible for implementation of the Project was not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

_____
_____
_____
_____

4. Is any facility with which the applicant is involved, or has any facility with which the applicant or other person or entity listed in Questions 1 & 2, above, ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to an action to suspend, revoke or limit the licensure or certification at any facility. If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility, and any final disposition reached by the applicable governmental authority.

_____
_____
_____
_____

5. Has the applicant, or other person listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense connected in any way with the ownership, development or management of the applicant facility or any health care facility listed in response to Question 1 & 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

_____
_____
_____
_____

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or authorized agent of the applicant for the proposed or existing facility.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

_____ _____

Date

Signature of Owner or
Authorized Agent of the Applicant